South Carolina Department of Disabilities and Special Needs

RESIDENTIAL RESPITE

Consumer Name: _____ Consumer SSN: _____

DSN Board/Private Provider: _____

Proposed Respite Description

Residential Program In Which Respite Is To Be Provided: _____

Type of Residential Program (e.g., CTH-I, CTH-II, CRCF, ICF/ID): _____

Estimated Duration Of Respite (Dates): _____

Reason For Respite:

_____

_____

_____

Is there sufficient licensed bed capacity to accommodate respite? ☐Yes ☐No

Is consumer to receive respite compatible with other consumers residing in home? ☐Yes ☐No

Have other consumers agreed to respite? ☐Yes ☐No

Has other consumer agreed to use of bedroom (if applicable)? ☐Yes ☐No

Proposed Resolution (if "No" checked on either of three previous questions):

_____

_____

_____

DSN Board/Private Provider Certification

I hereby certify that the information contained in this report is accurate.

_____ Date: _____

Executive Director Signature

DDSN Approval

_____ Date: _____

Assistant District Director

_____ Date: _____

District Director

(submit to DDSN District Office Assistant District Director)